Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 5/5/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
The item in dispute is the prospective medical necessity of OP ASC Left L3-4 Tran Epidural w/Selective Nerve Root Block.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld (Agree)

☒ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of OP ASC Left L3-4 Tran Epidural w/Selective Nerve Root Block.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:
The male injured his low back on xx/xx/xx. The mechanism of injury was that he bent down. He was diagnosed with lumbago/back pain, lumbar spine radiculopathy, and a pseudoarthrosis, with a history of L4-S1 decompression and fusion in 11/8/05. EMG/NCV was noted to have been unremarkable. Treatment has included medications, physical therapy, lumbar epidural steroid injections, and chiropractic. The 10/10 dated ESI was noted to have had dramatic symptom-decreasing efficacy for at least a year. On 11/22/13; he complained of low back pain. Exam findings included paraspinal muscle tenderness, decreased sensation in the lateral aspect of the thighs, positive straight leg raise bilaterally, 4/5 strength in the left extensor hallucis longus and tibialis anterior muscles,

along with left calf atrophy. A Lumbar MRI dated 12/27/13 revealed L3-4 facet degenerative and L4-S1 post-operative changes. On 4/4/14, complaints of low back and left leg pain continued. Exam findings were unchanged from 11/22/13 and also included absent Achilles reflexes. Medications included methacarbamol, Relafen, Lyrica, Celebrex, Soma, and Ultram. Prior denials noted the lack of detailed positive response from prior injections and the lack of recent comprehensive less invasive treatments, along with the considered injection being not correlated with the MRI findings.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The claimant has a combination of subjective and objective neurologic findings that evidence clinical radiculopathy. Prior injections have been documented to markedly decrease symptoms and increase functionality for over a year. The abnormal clinical findings are recently correlated by the MRI abnormalities, with the injection level being within reasonable proximity to the documented pathology. Reasonable and recent non-operative/ less invasive treatments including extensive medications and restricted activities have been tried and failed. Therefore, both for diagnostic and therapeutic purposes; the request is medically necessary at this time as it corresponds to the ODG criteria.

ODG Lumbar Spine: Diagnostic Epidural Steroid Transforaminal Injections/Selective Nerve Root Blocks: Diagnostic epidural steroid transforaminal injections are also referred to as selective nerve root blocks, and they were originally developed as a diagnostic technique to determine the level of radicular pain. In studies evaluating the predictive value of selective nerve root blocks, only 5% of appropriate patients did not receive relief of pain with injections. No more than 2 levels of blocks should be performed on one day. The response to the local anesthetic is considered an important finding in determining nerve root pathology. (CMS, 2004) (Benzon, 2005) When used as a diagnostic technique a small volume of local is used (<1.0 ml) as greater volumes of injectate may spread to adjacent levels. When used for diagnostic purposes the following indications have been recommended:

1) To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below:

2) To help to evaluate a radicular pain generator when physical signs and symptoms differ from that found on imaging studies;

3) To help to determine pain generators when there is evidence of multi-level nerve root compression;

4) To help to determine pain generators when clinical findings are consistent with radiculopathy (e.g., dermatomal distribution) but imaging studies are inconclusive;

5) To help to identify the origin of pain in patients who have had previous spinal surgery.

Epidural steroid injections-Criteria:
Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

(1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.
(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).
(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.
(4) Diagnostic Phase: At the time of initial use of an ESI (formally referred to as the "diagnostic phase" as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections.
(5) No more than two nerve root levels should be injected using transforaminal blocks.
(6) No more than one interlaminar level should be injected at one session.
(7) Therapeutic phase: If after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007)
(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.
(9) Current research does not support a routine use of a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more

than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.
(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.
(11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**